

# National policies for healthy aging in Malta: achievements and limitations

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**Background:** Contemporary public policy in Malta is strongly geared toward improving the levels of healthy aging of present and incoming cohorts of older persons.

**Methods:** A content analysis of contemporary policy directions launched and implemented by the Government of Malta toward healthy aging in Malta.

**Results:** Healthy aging policy in Malta follows the European Commission's document *Guiding principles for active aging and solidarity between generations* which underlined how societies must not be solely content with a remarkable increase in life expectancy, but must also strive to extend healthy life years, and to provide opportunities for physical and mental activities adapted to the capacities of older individuals. The government of Malta employs 14 consultant geriatricians who work mainly in the public rehabilitation hospital and residential/nursing homes, concentrating on frail elders, and in specialty clinics—for example, on memory, falls, and continence. Maltese policies on healthy aging include the *National Strategic Policy for Active Aging*, *National Demetria Strategy*, and the *Minimum Standards for Care Homes in Malta*, all of which include a range of recommendations that aim to lead older persons toward higher levels of healthy aging, but which also include a number of limitations.

**Conclusions:** In achieving better levels of healthy aging—that is, the process of optimizing opportunities for physical, social, and mental wellbeing to enable older people to enjoy an independent and good quality of life—this paper recommends 4 distinct and urgent pathways in healthy aging policy: addressing the further prevention and reduction of the burden of excess disabilities, chronic disease, and premature mortality; instigating an increased responsiveness to reducing risk factors associated with major diseases by taking comprehensive action to control the use of tobacco, increase physical activity for older adults, and the adoption of national nutrition action plans; investing more human and financial resources in long-term care services in the community and older persons' homes; and upholding further national capacity for training in geriatric training.

**Keywords:** Healthy aging, Active aging, Dementia, Malta

Transforming society's perception of aging from one of an expectation of dependency and decline to that of an opportunity to actively participate in the labor market and society requires a paradigm shift that enables higher levels of healthy aging. In its quest to respect the rights of older persons to lead a life of dignity and independence, and to participate in social and cultural life, Maltese national policy caters for the creation of the necessary conditions that allow older persons to remain full contributing

members of society rather than assuming a role of welfare recipients. Indeed, aging policy in Malta follows the European Commission's vision *Guiding principles for active aging and solidarity between generations* which underlines how societies must not be solely content with a remarkable increase in life expectancy, but must also strive to extend healthy life years by providing opportunities for physical and mental activities that are adapted to the capacities of older individuals<sup>[1]</sup>. Strengthening measures of health promotion, care and protection, as well as disease and injury prevention at all ages, enables older persons to lower their probability of illness and disability, while aiding them to ensure high physical and mental functioning that fosters independent living.

This paper presents key developments in Maltese public policy related to healthy aging. Following this brief introduction, the subsequent section presents key trends on the present and future demographics of population aging in Malta, and the analogous development of public geriatric services. The third to fifth sections focus on healthy aging policies—namely, the *National Strategic Policy for Active Aging*, *National Demetria Strategy*, and the *Minimum Standards for Care Homes in Malta*—which were launched and implemented precisely to improve the levels of health aging among present and incoming cohorts of older persons in Malta. The final section brings the paper to a close by forwarding proposals for the future of healthy aging policy in Malta.

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## Aging transitions and geriatric services

In 2015, more than one quarter of the total population, 25.6% or 111,281 persons, were aged 60-plus<sup>[2]</sup>. The largest share of the older population is made up of women, 54% of the total. In fact, the sex ratios for cohorts aged 80- and 90-plus numbered 63.7 and 70.6, respectively, which means that among the oldest cohorts there is more than twice the number of older women than men<sup>[3]</sup>. Such fluctuations were largely the result of a declining birth rate, together with an increasing life expectancy for both men and women. While at the beginning of the 20th Century life expectancy in Malta was around 43/46 years for men/women, in 2014 it reached 79.97/84.37 years, respectively<sup>[4]</sup>. It is noteworthy that Malta registers record results in “healthy life expectancy,” a concept which monitors the years of life that are lived in good health. While on average across the European Union Member States the healthy life expectancy at birth was 61.8/61.4 years for women/men, Malta registered first ranking for women (74.6 y) and second ranking for men (72.6 y) after Sweden (74.0 y)<sup>[5]</sup>. The 2011 Census reported that 61% of all deaths involved persons aged 75-plus, and that 47% of persons aged 60-plus experienced an “illness/health condition” that included “physical disability,” “blindness or partial sight loss,” and “deafness or partial hearing loss” in that respective order<sup>[6]</sup>. At the same time, the number/percentage of Maltese people over 60 years of age with dementia in 2017 was 6071 (1.4% of the Maltese population), and it is projected that these figures will rise to some 10,000 persons (2.3% of the Maltese population) in 2030<sup>[7,8]</sup>.

The 2011 Census reported a positive and negative correlation between age on one hand, and illiteracy and educational qualification/attainment on the other (respectively)<sup>[6]</sup>. The total illiteracy rate stood at 6.4%, of which 53.5% were aged 60-plus. Among the latter cohort, while 6.8% and 53.5% of persons never went to school and held a primary education level, respectively, 71.5% held no educational qualifications. In 2015, immigration was the main driver behind population growth, with the number of immigrants (12,831) being almost triple the number of births (4325), and with the difference between immigration and emigration being the highest for the decade at 4176<sup>[9]</sup>. Third-country nationals, European Union nationals, and Maltese citizens accounted for 44%, 43%, and 13%, respectively, of total immigration. Data from 2013 indicate that the majority of immigrants who acquire Maltese citizens are from Australia, followed by the United Kingdom and the United States. This immigrating trend is not functioning to increase population aging in Malta, as two-thirds of immigrants were males aged between 20 and 29<sup>[10]</sup>. The population of Malta is expected to rise considerably, to reach 468,900 in 2050<sup>[10]</sup>. Although the annual number of births is projected to fall over this period, the annual number of deaths will continue rising at much faster rates. In fact, by 2050 the population of persons aged 65-plus is projected to increase to 124,200—a 50% increase to 2015 figures<sup>[10]</sup>.

In 2000, the World Health Organization classified Malta as the fifth best performing health system from a total of 191 countries, as health care in Malta boasts exceptional levels of equity by being available to all citizens irrespective of income<sup>[11]</sup>. As far as geriatric services are concerned, Malta has come a long way in the past quarter of a century. Geriatric medicine has been established in Malta since the year 1989 when the first consultant geriatrician post was advertised and filled in the state-run health services, and post of

lecturer in geriatrics was created at the University of Malta<sup>[12]</sup>. The 1990s also witnessed the opening of an assessment and rehabilitation hospital specifically for older persons to enable them to return back into the community following hospitalization, and the inauguration of a Department of Gerontology at the University of Malta to run graduate and doctorate studies in gerontology, geriatrics, and dementia care<sup>[13]</sup>. Postgraduate training in Geriatric Medicine involves a foundation program and the obtainment of a Basic Specialist Training certificate, followed by a Higher Specialist Training post in Geriatric Medicine. This latter is a 4-year training post which involves a rotation through acute, rehabilitation, chronic, respite, and community care. Trainees also have an opportunity to gain experience in psychiatry of the old age, orthogeriatrics, and palliative care and continence services.

Presently, geriatric medicine is recognized as a separate specialty, with the government of Malta employing 14 consultant geriatricians who work mainly in the public rehabilitation hospital and residential/nursing homes, concentrating on frail elders, and in specialty clinics—for example, on memory, falls, and continence<sup>[14]</sup>. This means that there is a consultant geriatrician for every 7948 persons aged 60-plus (2015 figures)—which compares well to other European Union nations such as Germany (7496), Spain (7701), United Kingdom (8871), and Switzerland (9250)<sup>[15]</sup>. Geriatricians also provide geriatric assessments to older persons in their residences who, due to their high multimorbidity challenges, are housebound and cannot reach outpatient hospital clinics. Geriatricians are also involved in the “community geriatrics” service by carrying out domiciliary visits to provide access for homebound older people to a geriatric medical review, assess and manage older persons admitted to the orthogeriatrics unit; coordinate health center clinics dealing with memory problems, falls, movement disorders, continence problems, visual impairment and respiratory diseases; and a liaison psycho-geriatrician serves an increasing number of older persons with cognitive, mental and behavior problems, and persons with dementia.

In parallel to the above geriatric services, the government coordinates various community care services to aid older persons to age-in-place which include the handyman service, distributing diapers at a heavily subsidized prices, night-shelters, respite service, Active Aging Hubs and Dementia Care Centers, telecare services, home help service, meals-on-wheels service, and the “Live-in Carer” service whereby the state provides financial support to older persons who employ a full-time carers<sup>[3]</sup>. Domiciliary health services include an interdisciplinary team made up of administrative staff, nurses, occupational therapist, podiatrists, personal caregivers, physiotherapists, social workers, and a dementia intervention team. Although the quality of these services can be variable, and there are gaps in service coverage and limited choices for care recipients, many community-dwelling older persons credit these services for improving their quality of life and the only reason whereby they can remain living in their residences and not enter residential or nursing care<sup>[12]</sup>.

## National strategic policy for active aging

In its drive to improve the levels of health aging, one of the first national policies launched by the Government of Malta to work toward such an objective included the *National Strategic Policy for Active Aging*<sup>[16]</sup>. Including a total of 75 policy

recommendations, as much as one third of them focus on healthy aging, with the remaining 2 themes being active participation in the labor market and social participation. The *Strategic Policy* underlined that society should not be content solely with a remarkable increased life expectancy, but must also strive to extend healthy life years. Strengthening measures of health promotion, care and protection, as well as disease and injury prevention at all ages enables older persons to lower their probability of illness and disability, while aiding them to ensure high physical and mental functioning that fosters independent living. This entails the opportunity to live in age-friendly and accessible housing that are sensitive to the needs of and services sought by older individuals, and which provide accessible transportation for independent living. The policy's recommendations that are related to healthy aging included the following:

#### *Health prevention and promotion*

- Ensuring that health promotion and disease prevention adopt a life course perspective.
- Targeting falls in older adults through the creation of falls prevention programs.
- Creating and auditing strategies to ensure medication safety for older adults.

#### *Acute and geriatric rehabilitation*

- Targeting older adults to become better informed consumers of health care.
- Strengthening community health and rehabilitation services in order to allow a seamless transition between hospital-based and community services or other settings.
- Integrating acute geriatric care and rehabilitation within the acute public hospital.

#### *Mental health and wellbeing*

- Increasing health literacy and decreasing stigma on mental health and wellbeing through education strategies targeting both the general public and health care providers.
- Integrating mental health services within acute public hospital systems to address the complex needs of older persons and decrease the stigma associated with mental illness.
- Strengthening the current geriatric mental health services, and expanding such services to meet the needs of older persons in the community.

#### *End-of-life care*

- Improving the training opportunities in end-of-life and palliative care for persons working in the social and health care sectors.
- Creating legislation to introduce advance directives for health care.
- Developing and implementing policies and procedures in health care facilities concerning end-of-life issues, including but not restricted to artificial feeding and resuscitation.

Although Malta's *National Strategic Policy for Active Aging* has been in receipt of positive reviews in the academic press<sup>[17]</sup>, it remains that it includes serious omissions. At the outset, its neglect of the feminization of aging, and its impact on healthy aging, outcomes, and services, is problematic. Compared with male peers, older women face crucial inequities related to health, and as a result, active and healthy aging policies warrant a significant focus on the unique needs of women that supports a gendered approach to policy and intervention development, and the promotion of the female-friendly health process and outcomes across the life course. There is no doubt that policy makers, health care workers and researchers need to consider the perspective of gender as well as age when implementing and evaluating effective interventions<sup>[18]</sup>, and

the Maltese active aging policy falls flat in this regard. The policy's neglect of risk behaviors, nutrition, and exercise is also noteworthy, when considering that studies showed tobacco and alcohol still remain common abused substances in later life, older women and older persons in general (defined 55-plus) recorded the highest rates of obesity and being overweight, respectively, in Malta, and that among persons aged 65-plus physical inactivity becomes the norm<sup>[19]</sup>. Moreover, although Malta is experiencing a steep exponential increases in sexually transmitted infection and HIV cases among older persons, particularly men, no mention is found within the active aging policy on sexual health. Indeed, while Malta's rate of new HIV cases among people over 50 is in the top 4 for European countries<sup>[20]</sup>, the nation's only genitourinary clinic has recently uncovered an increasing number of older persons carrying herpes and genital warts<sup>[21]</sup>. These latter, who were in their 60s and 70s, included both married and divorced men who tended to have attended massage parlors which serve as a front for prostitution. Another lacuna in the strategy is that it fails to underline that while mental health and wellbeing call for comprehensive community care services as a major opportunity for preventive health care, end-of-life care should also include bereavement, palliative and hospice services, and options for dying at home as an alternative to hospital settings. Finally, the relative lack of emphasis on alternative therapies and remedies means that the strategy does not provide a reaction toward the strong medical bias within the existing Maltese health system, especially the widely held belief that "old age" is a disease, and hence, that tests and treatments are irrelevant. Thus, the strategy fails to encourage a holistic approach toward the medical treatment of older patients, whereby an attempt is made not only to treat the specific condition or conditions, but also to make sure there is sufficient physical activity, proper nutrition, and family caregiving and support at home.

## **National dementia strategy**

The importance of addressing dementia care did not pass unnoticed by the government. A National Focal Point on Dementia was set up in 2013 to work on, and present, a series of recommendations that would enhance local dementia services and address shortfalls in dementia care, through the planning and development of a range of community and institutional dementia care services<sup>[22]</sup>. The National Focal Point on Dementia presented the government the much anticipated *National Dementia Strategy*<sup>[23]</sup> in 2015. Malta was therefore the 21st country to have a 9-year plan aimed at enhancing the quality of life of persons with dementia and their family carers<sup>[22]</sup>. The strategy included the following key objectives.

*Increasing awareness and understanding of dementia.* One fundamental aspect of this strategy is to increase awareness and understanding of dementia among the general public and health care professionals in order to reduce stigma and misconceptions about the condition.

*Timely diagnosis and intervention.* Early symptom recognition and interventions through appropriate referral pathways together with the necessary pharmacological, psychological, and psychosocial support offer the best possible management and care for individuals with dementia. This strategy also encourages the development of advanced care directives.

*Workforce development.* Good quality care will be ensured through the provision of training and educational programs for staff in direct contact with individuals with dementia giving

particular importance to challenging behavior and palliative care. Caregivers and family members also be provided with adequate.

*Improving dementia management and care.* A holistic approach in service provision for individuals with dementia, their caregivers and family members will be adopted. Apart from providing all pharmacotherapeutic options to Alzheimer disease patients, individuals receiving a diagnosis of dementia will have care plans developed by a multidisciplinary team.

*Ethical approach to dementia management and care.* This strategy aims to promote an ethical approach to dementia management and care and provide individuals with dementia and their caregivers with the necessary psychological support needed in making important decisions regarding their health and welfare.

*Research.* Information regarding epidemiology of dementia in Malta, patterns of detection and diagnosis, and delivery of care are needed for proper planning and allocation of health and social care funds and for outcome evaluation. Since the delivery of care is context specific, the strategy aims to promote and support epidemiological research in the field of dementia.

The launch of the *National Dementia Strategy* had an instant effect as the government embarked on an immediate implementation of the policy's recommendations. Results included improved diagnosis and assessment through memory clinics; improved access to care through single-point access and improved access for minority groups; improved care coordination through seamless transitions between different care settings; improved person-centered care by an increased focus on including patients in health care decisions; improved resources through dementia care centers which provide practical and emotional support, reduce social isolation, promote self-care, and a source of information for future health care decisions; caregiver support through a better access to respite services, coping strategies, and peer supports; housing support by better home-based support, including home modifications and a wider range of home care and rehabilitation services; more adequate long-term care by establishing dementia-friendly wards; more public awareness on dementia by setting a national campaign and a 24-hour Freephone helpline; education of the workforce on dementia by providing mandatory training to all nurses working with older persons both in the community or long-term care; improved epidemiological surveillance by the setting up of a public-funded dementia intervention team (consisting of a coordinator, nurse, psychologist, occupational therapist, and social worker) to visit all newly diagnosed persons with dementia; and finally, increased research through the launching of graduate and doctorate programs in dementia studies at the University of Malta.

However, the strategy tends to be overly confident of the benefits of specialize services for improving the quality of life of persons with dementia, while also overlooking how improved dementia care may be achieved by strengthening present services in primary care rather than reinventing the wheel by creating dementia specialized services. Indeed, the strategy's assumption that primary care is the Achilles heel of dementia care for being too slow to identify or diagnose dementia, slow to refer to specialized services, and lacking the expertise to manage the condition is unfounded. Indeed, research studies demonstrated that speedy and efficient diagnosis can be achieved accurately by primary care team staff<sup>[24]</sup>. Hence, a potential overlooked strategic recommendation is to maximize the strengths of primary care staff in dementia care assessment and investigation, and making use of them in the ongoing support of individuals who remain recognized, respected, and not displaced from their

natural community—which would draw considerable savings in comparison to founding secondary care center services<sup>[25]</sup>.

### Minimum standards for care homes for older persons

For many years, long-term care for older persons was the sole responsibility of religious authorities, and it was only in recent centuries that the state started to provide residential/nursing care to frail elders<sup>[26]</sup>. In 2017, the number of licensed care homes for older people—run by the private sector, the Church and the public sector—numbered 46, with the number of licensed beds being 5390—that is, 4.84% of the total 60-plus population if one takes the 2015 figures. Research is critical of the gerontological and geriatric outcomes of local care homes, highlighting how entry and living in long-term care facilities impacts negatively quality of life<sup>[27]</sup>. Residents are often found to be marginalized and excluded from management decisions, with negative impacts of care home life including lack of privacy and dignity, regimented routines that engender feelings of emptiness, lack of self-control and learned helplessness<sup>[26]</sup>.

In response to such critical reports, the Government of Malta launched in 2015 the *Minimum Standards for Care Homes for Older Persons*<sup>[28]</sup>. The 38 standards stipulate the minimum requirements of the required knowledge, skills and competencies needed by management and staff to ensure care homes deliver individually tailored, comprehensive and quality services. The Standards include 38 policy endorsements. Standards 1–5 concern the home's obligations. Each care home shall provide a written and comprehensive Guide for Residents, which sets out the statement of purpose, the range of facilities, and the terms and conditions on which all services are provided in the contract with each resident. All prospective residents shall thereby be able to make informed choices about whether or not the home is able to meet the individual's particular needs. Standards 6–10 relate to health and personal care. Residents' health and personal care shall be based on their specific individual needs and wishes within reason. Therefore, the assessment process and the individual's plan of care are seen as crucial in maintaining standards. The care plan should be a dynamic document, which must be reviewed and may be changed regularly according to the assessed needs of the resident. Standards 11–15 concern daily life and social activities. Older individuals continue to have social, cultural, spiritual, and recreational needs and interests, and therefore should enter a care homes with a wide variety of expectations and preferences. Standards 16–18 focus on complaints and protection by addressing the matter of how residents and/or their relatives and representatives can make complaints about anything that goes on in the home, both in terms of the treatment and care provided by staff and/or the facilities that are available. Standards 19–26 concern the environment. All new homes shall be constructed in such a way that the living space suits all residents' needs. They shall provide single and double rooms with accessible en-suite showers and toilets. Standards 27–30 focus on staffing issues. In determining appropriate staffing contingents in all care homes, the regulatory requirement that staffing levels and skills mix are adequate to meet the assessed and recorded needs of the residents. Standards 31–38 relate to management and administration issues by clarifying the qualities and qualifications required of the persons in day-to-day control of the delivery of care, and how they should exercise their responsibilities.

Through these standards the intention that older residents in care homes are able to experience positive levels of quality life, by aging positively and successfully despite their health limitations, became increasingly conceivable. However, the standards, and underlying policy strategy, are not devoid of lacunae. The policy document is devoid of a costings plan, with the national budgets for long-term care remaining static for the past 2 years, when it is evident that implementing the new staffing requirements will obviously add to higher costs. Moreover, no impact assessment was done to examine the relative effectiveness of proposed strategies, and there is an urgent need to focus less on measurement issues and more on which standards actually improve quality of care. Another lacuna is that the standards presuppose a relatively complex expertise on behalf of care homes to develop and analyze data, and then use such data to guide the required management changes. The extent that care homes have the organizational capacity to meet such an objective is not tackled when it is well known that most facilities, especially private homes, operate with sparse human resources. The government's choice of the "stick," rather than the "carrot," approach to ensure good quality care—through the legislation of fines for care homes which do not uphold the standards is problematic when research noted that it is more profitable for entities to absorb cautionary fines than implement wide-ranging structural and workforce changes<sup>[29]</sup>. Public policy makers need to find a way to establish incentives for providers to provide good care and also to find a way to incorporate quality of life concerns into the licensing process. Indeed, state regulation remains a blunt instrument and the inevitable reality is that surveyors can only directly observe care a very small percentage of the time<sup>[30]</sup>. Finally, one notes that the government erroneously hinged long-term care services upon institutional and residential care when, in fact, long-term care constitutes a fragmented systems of services. On one hand, no mention is made to the fact that long-term care encompasses a variety of day and respite care services that include rehabilitation therapy, personal assistance and care, and homemaker/chore services. On the other hand, the need for alternative types of supportive housing—ranging from independent living facilities which offer age-friendly amenities and events for older persons who are still relatively independent but prefer contact with other people of their age, to assistive living facilities which provide meal and housekeeping services on an as-needed basis to residents who continue living in separate quarters.

## Conclusions

It is positively noteworthy that Malta holds record levels of life and healthy life expectancies, to the extent that the country's population is currently one of the most aged populations among European Union Member States. Malta's population aging trend is a demographic movement to be taken with certainty, and indicators, both absolute and positive, point at its future continuation. Indeed, projections indicate clearly that Malta will be one of the fastest aging countries in the European Union, and in approximately half a decade one in 5 Maltese are projected to be over age 65 (European Commission, 2015). It is also positive to note that enabling a greater proportion of older people to stay healthy and active is a key priority for Malta's public policy. It is to the government's credit that the past 4 years witnessed the launch of 3 influential policy frameworks—namely, the *National Active Aging Policy*, *National Dementia Strategy*, and *Minimum standards for Care Homes for Older People*—which, despite its

lacunae listed herein, offer opportunities for improved levels of physical, social and mental wellbeing for older and aging persons. The fact that the implementation of the policies' recommendations proceeded with immediate effect—in line with the continued coordination of a range of geriatric, domiciliary, and geriatric care services for frail community-dwelling older persons to assist them to continue "aging-in-place"—is also commendable.

However, this is not the same as saying that Malta's quest in achieving better levels of healthy aging incorporates no lacunae. The fact that recent trends in healthy life years show no distinct improvement, warrants 4 distinct and urgent pathways in healthy aging policy. First, Maltese public policy needs to address better the prevention and reduction of the burden of excess disabilities, chronic disease, and premature mortality by setting measurable targets for improvements in health status and the reduction of chronic diseases, disabilities, and premature mortality. More efforts are required in establishing age-friendly screening services, health care centers, and holistic standards that prevent the onset or worsening of disabilities. Secondly, increased responsiveness to reducing risk factors associated with major diseases by taking comprehensive action to control the use of tobacco, developing appropriate guidelines on physical activity for older adults, and national nutrition action plans are immediately needed. Moreover, promoting oral health among older people, as well as determining the extent of misuse of drugs and medication remain relatively absent in national healthy aging policies. Thirdly, Maltese public policy on healthy aging requires to find a more equitable balance the human and financial resources allotted to informal and formal care systems. An evolving, tailored and nonfragmented combination of chronic disease management, and especially, dementia care services, so as to allow frail older persons continue living at home, over the alternative of nursing home care, should be instantly prioritized. Finally, although substantial progress has been made in geriatric education in Malta the growing number of older persons requires further national capacity for training in geriatric training. The greatest challenge are the remaining gaps in the geriatric knowledge of general practitioners and other health professionals which are resulting in access problems and shortcomings in the quality of care for older persons at primary and acute health care systems. There is no doubt that allowing more people to lead active and healthy lifestyles in their later years requires investment in a broad range of policies, and these 4 strategic directions will continue thrusting Malta in the right and appropriate direction.

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